# Step 1: www.asiflex.com/GIC

# Step 2


ASI FLEX
Commonwealth of Massachusetts
Group Insurance Commission
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Campus: President's Office
First Name: Tony
Middle Initial:
Last Name: Parisio
SSN: 123-45-6780
Address 1: 123 Street
Address 2:
City: Columbia
State: MISSOURI
Zip Code: 65203
Home/Work Phone: (555) 555-5555
Extension: ____
Date Of Birth: 11/8/1973
Submit
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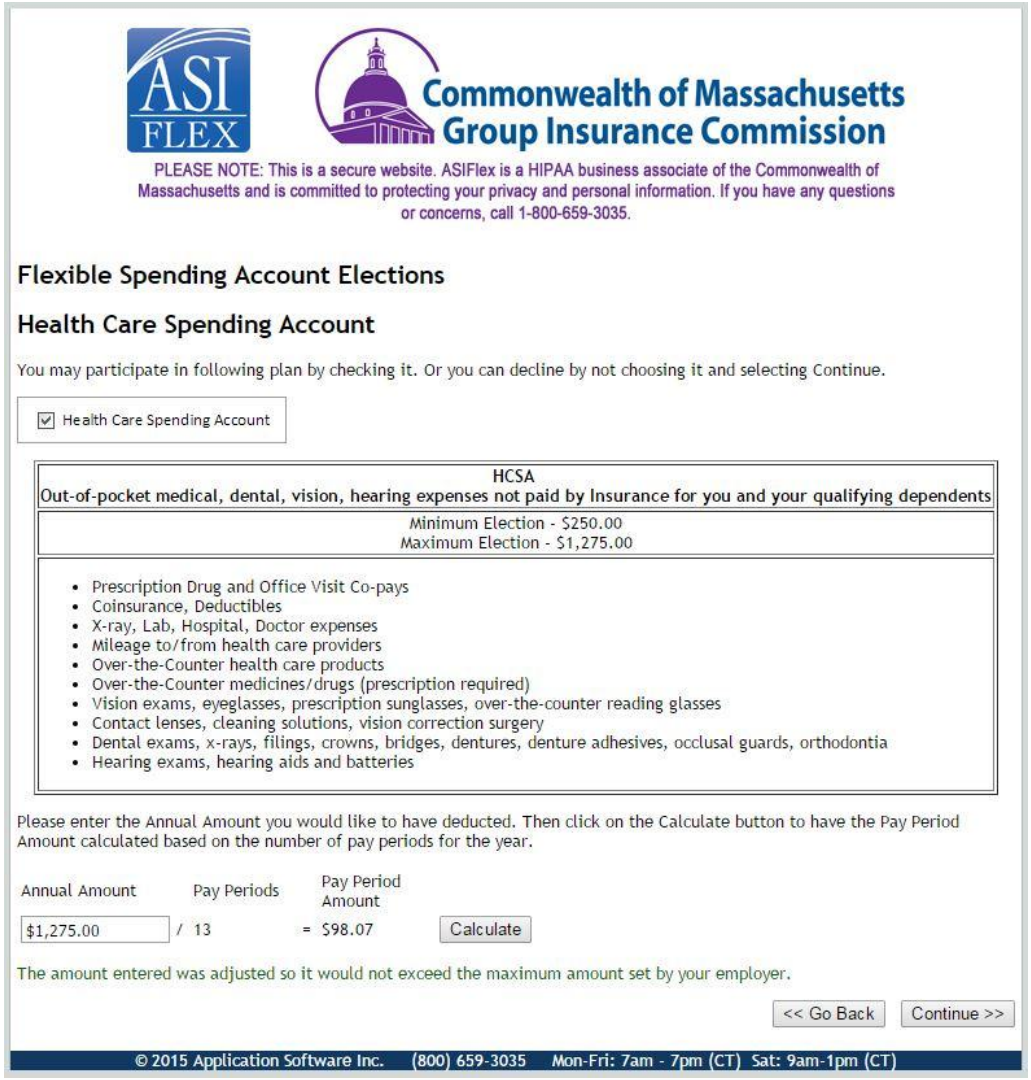
# Step 3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Flexible Spending Account Elections
Health Care Spending Account
You may participate in following plan by checking it. Or you can decline by not choosing it and selecting Continue.
Health Care Spending Account
HCSA
Out-of-pocket medical, dental, vision, hearing expenses not paid by Insurance for you and your qualifying dependents
Minimum Election - $250.00
Maximum Election - $1,275.00
Prescription Drug and Office Visit Co-pays
Coinsurance, Deductibles
X-ray, Lab, Hospital, Doctor expenses
Mileage to/from health care providers
Over-the-Counter health care products
Over-the-Counter medicines/drugs (prescription required)
Vision exams, eyeglasses, prescription sunglasses, over-the-counter reading glasses
Contact lenses, cleaning solutions, vision correction surgery
Dental exams, x-rays, filings, crowns, bridges, dentures, denture adhesives, occlusal guards, orthodontia
Hearing exams, hearing aids and batteries
Please enter the Annual Amount you would like to have deducted. Then click on the Calculate button to have the Pay Period Amount calculated based on the number of pay periods for the year.
Annual Amount
Pay Periods
Pay Period Amount
$1,275.00
/ 13
= $98.07
Calculate
The amount entered was adjusted so it would not exceed the maximum amount set by your employer.
<< Go Back
Continue >>
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# Step 4


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Flexible Spending Account Elections
Dependent Care Assistance Account
You may participate in following plan by checking it. Or you can decline by not choosing it and selecting Continue.
Dependent Care Assistance Account
DCAP
Child or adult daycare expenses while you work, look for work, or while your spouse is in full-time school
Note: This is not health care
Minimum Election - $0.00
Maximum Election - $2,500.00 ($1,250.00 if married, filing separate tax returns)
Work-related child or adult daycare expenses
Preschool (pre-kindergarten)
Nursery school
Before school or after school care
Day camps
Adult care for qualifying dependent age 13 or older
Please enter the Annual Amount you would like to have deducted. Then click on the Calculate button to have the Pay Period Amount calculated based on the number of pay periods for the year.
Annual Amount
Pay Periods
Pay Period Amount
$2,500.00
/ 13
= $192.30
Calculate
<< Go Back
Continue >>
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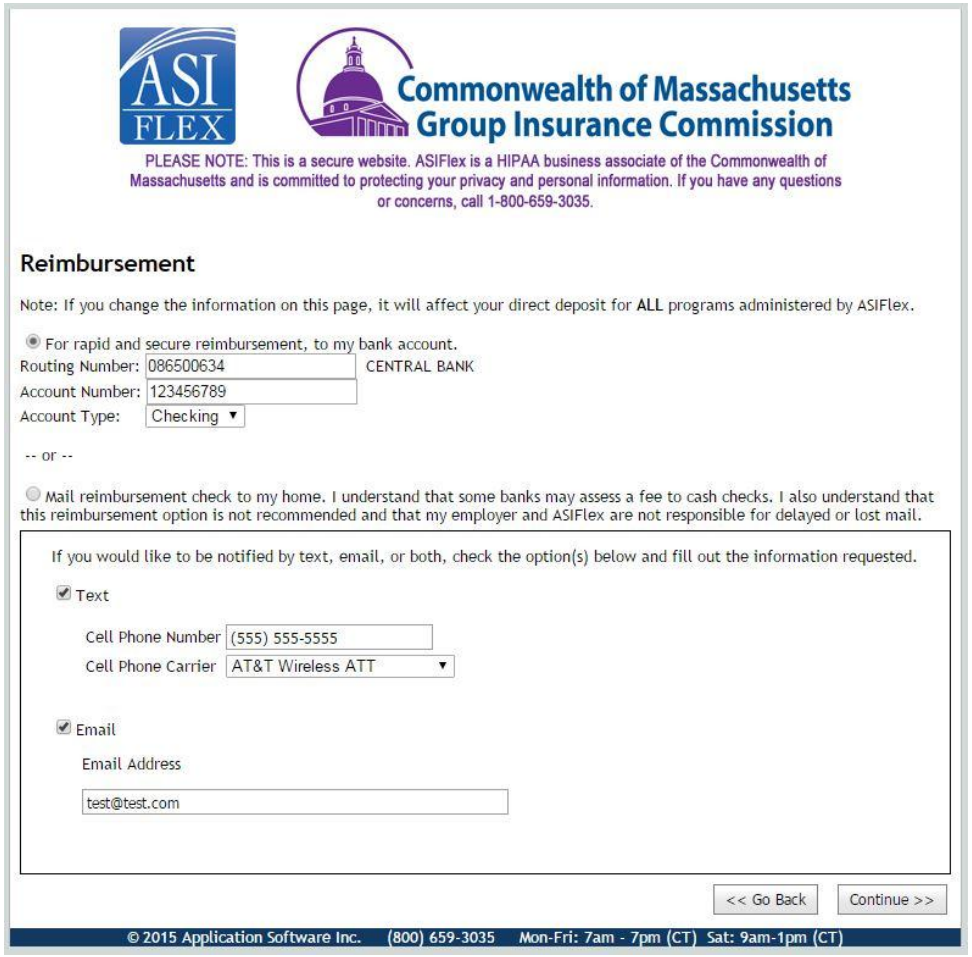
# Step 5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Reimbursement
Note: If you change the information on this page, it will affect your direct deposit for ALL programs administered by ASIFlex.
For rapid and secure reimbursement, to my bank account.
Routing Number: 086500634 CENTRAL BANK
Account Number: 123456789
Account Type: Checking
-- or --
Mail reimbursement check to my home. I understand that some banks may assess a fee to cash checks. I also understand that this reimbursement option is not recommended and that my employer and ASIFlex are not responsible for delayed or lost mail.
If you would like to be notified by text, email, or both, check the option(s) below and fill out the information requested.
Text
Cell Phone Number (555) 555-5555
Cell Phone Carrier AT&T Wireless ATT
Email
Email Address
test@test.com
<< Go Back
Continue >>
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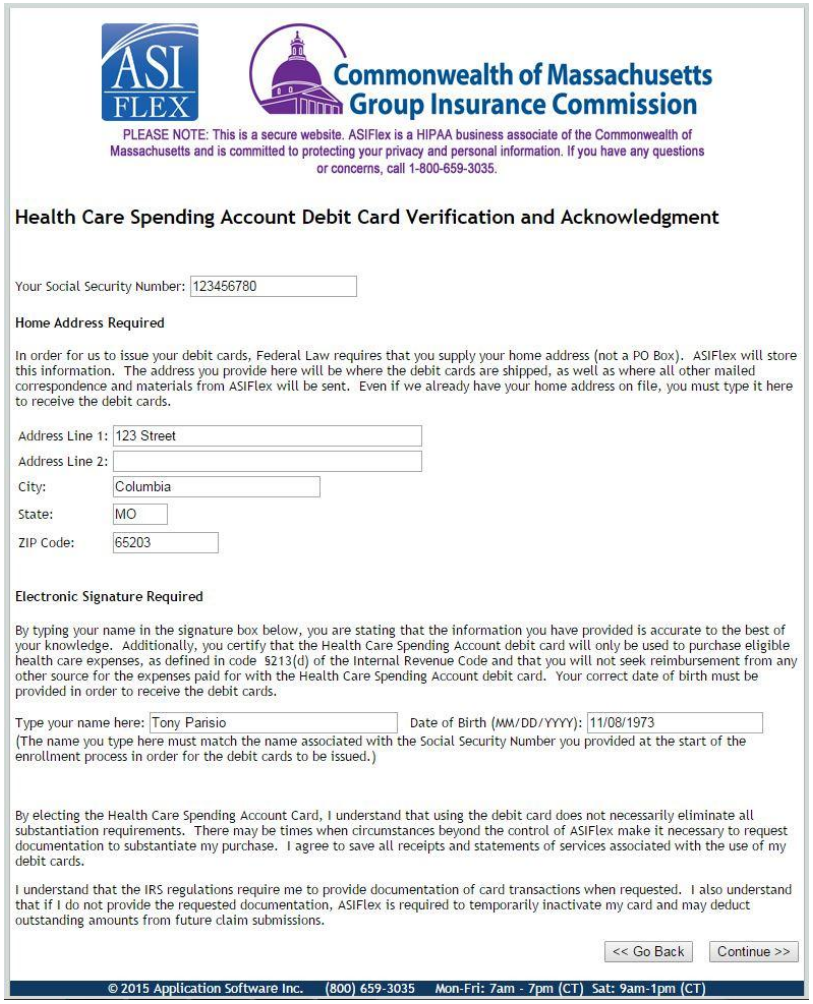
# Step 6



Commonwealth of Massachusetts
Group Insurance Commission

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**Health Care Spending Account Debit Card Verification and Acknowledgment**

Your Social Security Number: 123456780

**Home Address Required**

In order for us to issue your debit cards, Federal Law requires that you supply your home address (not a PO Box). ASIFlex will store this information. The address you provide here will be where the debit cards are shipped, as well as where all other mailed correspondence and materials from ASIFlex will be sent. Even if we already have your home address on file, you must type it here to receive the debit cards.

Address Line 1: 123 Street
Address Line 2:
City: Columbia
State: MO
ZIP Code: 65203

**Electronic Signature Required**

By typing your name in the signature box below, you are stating that the information you have provided is accurate to the best of your knowledge. Additionally, you certify that the Health Care Spending Account debit card will only be used to purchase eligible health care expenses, as defined in code §213(d) of the Internal Revenue Code and that you will not seek reimbursement from any other source for the expenses paid for with the Health Care Spending Account debit card. Your correct date of birth must be provided in order to receive the debit cards.

Type your name here: Tony Parisio  Date of Birth (MM/DD/YYYY): 11/08/1973
(The name you type here must match the name associated with the Social Security Number you provided at the start of the enrollment process in order for the debit cards to be issued.)

By electing the Health Care Spending Account Card, I understand that using the debit card does not necessarily eliminate all substantiation requirements. There may be times when circumstances beyond the control of ASIFlex make it necessary to request documentation to substantiate my purchase. I agree to save all receipts and statements of services associated with the use of my debit cards.

I understand that the IRS regulations require me to provide documentation of card transactions when requested. I also understand that if I do not provide the requested documentation, ASIFlex is required to temporarily inactivate my card and may deduct outstanding amounts from future claim submissions.

<< Go Back  Continue >>

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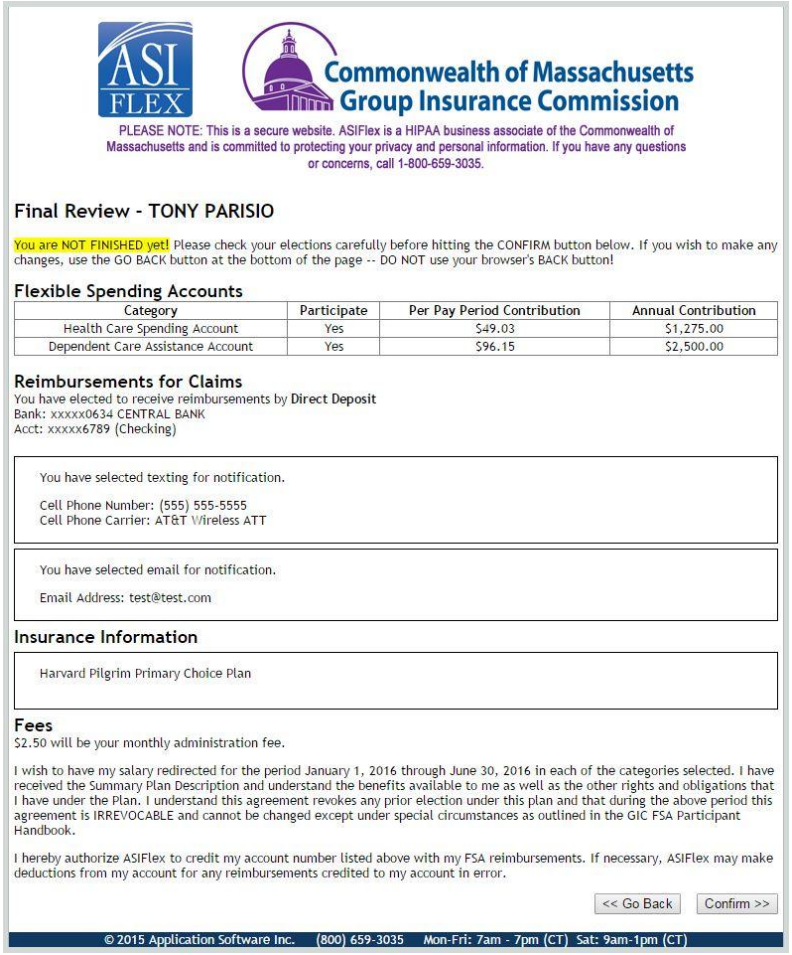
# Step 7


| Name | Plan Type | PCP Copay(s) | Specialist Copay(s) |
|---|---|---|---|
| Fallon Health Direct Care | HMO - Limited Network Plan | $15 | $25 |
| Fallon Health Select Care | HMO | $20 | $25/$35/$45 |
| Harvard Pilgrim Independence Plan | PPO | $20 | $20/$35/$45 |
| Harvard Pilgrim Primary Choice Plan | HMO - Limited Network Plan | $20 | $20/$35/$45 |
| Health New England | HMO - Limited Network Plan | $20 | $25/$35/$45 |
| NHP Care (Neighborhood Health Plan) | HMO - Limited Network Plan | $20 | $25/$35/$45 |
| Tufts Health Plan Navigator | PPO | $20 | $25/$35/$45 |
| Tufts Health Plan Spirit | EPO (HMO-Type) - Limited Network Plan | $20 | $25/$35/$45 |
| UniCare State Indemnity Plan/Basic | Indemnity | $20 | $25/$35/$45 |
| UniCare State Indemnity Plan/Community Choice | PPO-Type - Limited Network Plan | $20 | $25/$35/$45 |
| UniCare State Indemnity Plan/PLUS | PPO-Type | $15/$20 | $25/$35/$45 |
| Not enrolled in any plan listed above | | | |

# Step 8



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## Final Review - TONY PARISIO

You are NOT FINISHED yet! Please check your elections carefully before hitting the CONFIRM button below. If you wish to make any changes, use the GO BACK button at the bottom of the page -- DO NOT use your browser's BACK button!

### Flexible Spending Accounts

| Category | Participate | Per Pay Period Contribution | Annual Contribution |
|---|---|---|---|
| Health Care Spending Account | Yes | $49.03 | $1,275.00 |
| Dependent Care Assistance Account | Yes | $96.15 | $2,500.00 |

### Reimbursements for Claims

You have elected to receive reimbursements by **Direct Deposit**
Bank: xxxxx0634 CENTRAL BANK
Acct: xxxxx6789 (Checking)

You have selected texting for notification.

Cell Phone Number: (555) 555-5555
Cell Phone Carrier: AT&T Wireless ATT

You have selected email for notification.

Email Address: test@test.com

### Insurance Information

Harvard Pilgrim Primary Choice Plan

### Fees

$2.50 will be your monthly administration fee.

I wish to have my salary redirected for the period January 1, 2016 through June 30, 2016 in each of the categories selected. I have received the Summary Plan Description and understand the benefits available to me as well as the other rights and obligations that I have under the Plan. I understand this agreement revokes any prior election under this plan and that during the above period this agreement is IRREVOCABLE and cannot be changed except under special circumstances as outlined in the GIC FSA Participant Handbook.

I hereby authorize ASIFlex to credit my account number listed above with my FSA reimbursements. If necessary, ASIFlex may make deductions from my account for any reimbursements credited to my account in error.

<< Go Back  Confirm >>

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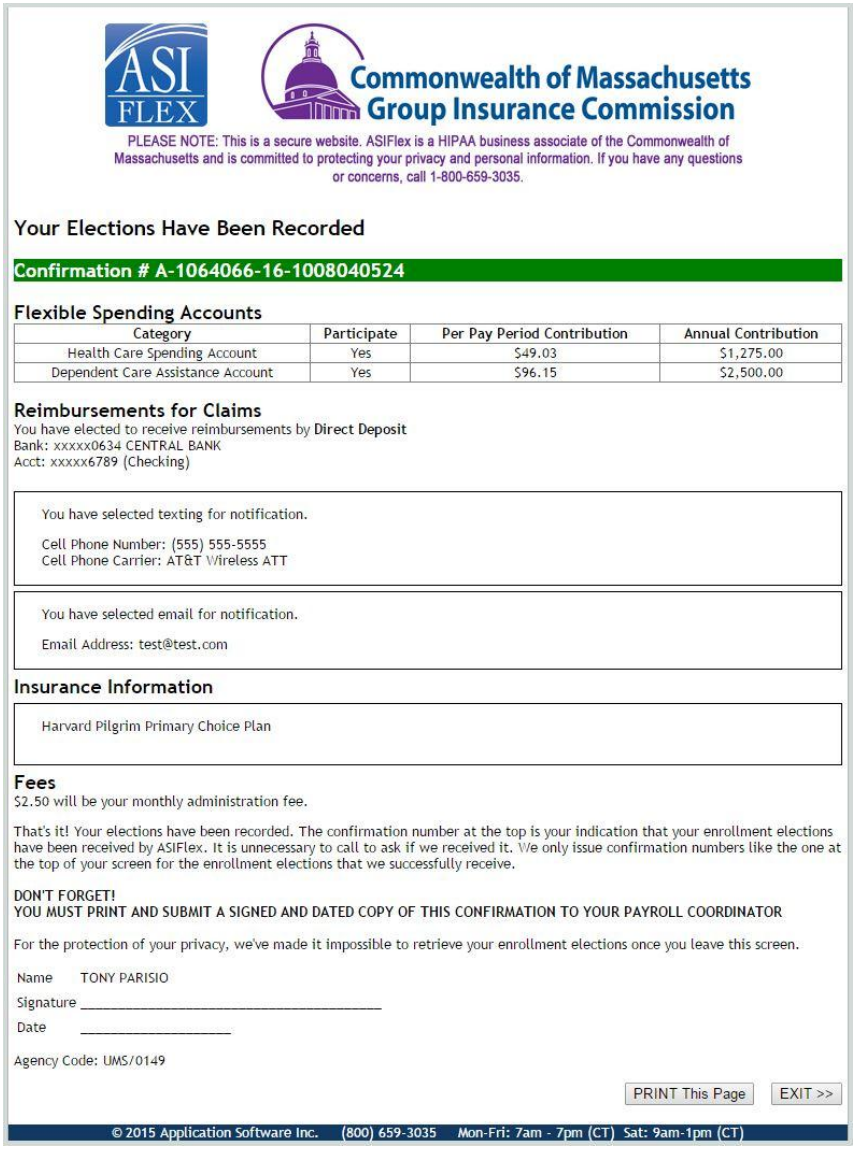
# Step 9 – Done!



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**Your Elections Have Been Recorded**

**Confirmation # A-1064066-16-1008040524**

**Flexible Spending Accounts**

| Category | Participate | Per Pay Period Contribution | Annual Contribution |
|---|---|---|---|
| Health Care Spending Account | Yes | $49.03 | $1,275.00 |
| Dependent Care Assistance Account | Yes | $96.15 | $2,500.00 |

**Reimbursements for Claims**

You have elected to receive reimbursements by **Direct Deposit**
Bank: xxxxx0634 CENTRAL BANK
Acct: xxxxx6789 (Checking)

You have selected texting for notification.

Cell Phone Number: (555) 555-5555
Cell Phone Carrier: AT&T Wireless ATT

You have selected email for notification.

Email Address: test@test.com

**Insurance Information**

Harvard Pilgrim Primary Choice Plan

**Fees**

$2.50 will be your monthly administration fee.

That's it! Your elections have been recorded. The confirmation number at the top is your indication that your enrollment elections have been received by ASIFlex. It is unnecessary to call to ask if we received it. We only issue confirmation numbers like the one at the top of your screen for the enrollment elections that we successfully receive.

**DON'T FORGET!**
**YOU MUST PRINT AND SUBMIT A SIGNED AND DATED COPY OF THIS CONFIRMATION TO YOUR PAYROLL COORDINATOR**

For the protection of your privacy, we've made it impossible to retrieve your enrollment elections once you leave this screen.

Name TONY PARISIO
Signature _____
Date _____

Agency Code: UMS/0149

PRINT This Page EXIT >>

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